



SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201
Sioux Falls, South Dakota 57106-3115
Phone: 605-362-2760

FILE COPY

May 16, 2011

Karlene Geffre, RN
Aberdeen Health & Rehabilitation Center
1700 N. Highway 281
Aberdeen, SD 57401

Dear Ms. Geffre:

Your application for re-approval of your Nurse Aide Training Program at Aberdeen Health and Rehabilitation Center utilizing *"How to be a Nursing Assistant"* 4th edition, an approved curriculum has been received in the Board Office.

Based on the information provided, you meet the qualification requirements to serve as Program Coordinator as set forth in ARSD 44:04:18:10. Your current RN licensure was verified, and you have a minimum of two years of nursing experience with at least one-year long-term care experience.

You will also serve as primary instructor and meet the requirements as set forth in ARSD 44: 04:18:11. The primary instructor is the actual teacher of course material and must have a minimum of two years nursing experience, at least one year of which is in the provision of long term care services.

All requirements are met for approval of your training program, and your approval status is valid through **May 2013**. At the time of renewal you may obtain a re-approval form on our website at www.nursing.sd.gov.

If you need further assistance, please call me at the above number.

Sincerely,

Nancy Bohr RN, MBA, MSN, FRE
Nursing Program Specialist

cc: Diana Weiland
South Dakota Department of Health

Enc Application Approval



SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
 4305 S LOUISE AVENUE SUITE 201 • SIOUX FALLS, SD 57106-3115
 (605) 362-2760 • FAX: 362-2768

APPLICATION FOR NURSE AIDE TRAINING PROGRAM

Please select: ☐ INITIAL APPROVAL

☒ REAPPROVAL

Please select: ☒ NURSING HOME BASED

☐ NON-NURSING HOME BASED

Based on Program Requirements, complete and submit to the South Dakota Board of Nursing:

INITIAL APPROVAL REQUIREMENTS

- ☐ Program Coordinator Vitae/Professional work history
- ☐ Primary Instructor Vitae/Professional work history
- ☐ Description of physical facilities for training programs
- ☐ Description of licensed nurse supervision of students
- ☐ Student:Instructor ratio in the clinical setting
- ☐ Listing of program length & distribution of hours

REAPPROVAL REQUIREMENTS

- ☐ Changes in Faculty, if any
- ☐ Changes in Course Syllabus, if any
- ☐ Changes in physical facilities for training programs, if any
- ☐ Changes in licensed nurse supervision of students, if any
- ☐ Changes in clinical Student:Instructor ratio, if any
- ☐ Changes in program length & distribution of hours, if any

COURSE SYLLABUS If using a Course Syllabus that has current Board of Nursing approval, you need not submit the Course Syllabus; if using a Course Syllabus that does not have current Board of Nursing approval Nursing, submit:

- ☐ Course overview
- ☐ Course objectives
- ☐ Content outline
- ☐ Skills training
- ☐ Teaching methodologies
- ☐ Methods of evaluation
- ☐ Environment for learning
- ☐ Student:Instructor ratio
- ☐ Names of required textbooks

Note: Written notification should be submitted to the South Dakota Board of Nursing if any substantive changes in Curriculum or Faculty are made within the two-year Approval Period.

FACILITY TO OFFER NURSE AIDE TRAINING PROGRAM

ADDRESS:

TEL: 605 225 7315 FAX: 605 225 0078 EMAIL: ~~karlene.geffre@tealwood.com~~ karlene.geffre@tealwood.com
 NAME OF COURSE: ADCA How To Be A Nurse Assistant Lyle ed.

FACULTY MEMBER NAME AND CREDENTIALS	STATE IN WHICH CURRENTLY LICENSED AS A NURSE	LICENSE #	EXPIRATION DATE	HAS TWO YEARS CLINICAL EXPERIENCE ONE YEAR IN LTC
PROGRAM COORDINATOR: <u>Karlene Geffre</u>	<u>SD</u>	<u>R024712</u>	<u>5-19-12</u>	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY INSTRUCTOR: <u>Karlene Geffre</u> If NEW Primary Instructor, attach "Train the Trainer" Certificate, or verification of adult teaching experience within the past five years				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

I affirm that the curriculum in use reflects the standards pursuant to ARSD 44:04:18 (10-15).

SIGNATURE OF APPLICANT/TITLE:

DATE: 5/11/11

THIS SECTION TO BE COMPLETED BY THE BOARD OF NURSING REPRESENTATIVE

DATE APPLICATION RECEIVED: 5-11-11 DATE APPROVED: 5-16-11

DATE APPLICATION RETURNED: DATE DENIED:

REASON FOR DENIAL:

EXPIRATION DATE OF APPROVAL:

BOARD REPRESENTATIVE:

Mary Baker RN, MBA, MSN, FAAN